PATIENT CONTRACEPTIVE ORDER FORM

This form is to be used to enable the Health Department to provide certain pharmaceuticals to women who are receiving Family Planning services from enrolled Plan First Service Providers. The Plan First provider remains to be the patient's medical home. The Health Department will provide contraceptive counseling to all patients. A new form is required if the provider makes any changes based on patient need/preference.

PATIENT INFORMATION:

Patient Name _____ Medicaid # _____

DOB _____ Date of Initial/Annual Family Planning Visit _____

PROVIDER INFORMATION:

I have completed the above mentioned patient's medical history and physical exam and request the following type of contraceptive be provided to my patient. I understand that the Health Department has a limited formulary and that a comparable, alternative oral contraceptive may be used. Please provide the following contraceptive to my patient:

- ☐ Low Dose Monophasic Combined OC (Preferred Pill): _____
- ☐ Low Dose Triphasic Combined OC (Preferred Pill): _____
- ☐ Monophasic 50 mcg OC
- ☐ Progestin-Only OC
- ☐ Contraceptive Patch
- ☐ Vaginal Ring

COMMENTS:_____

PROVIDER SIGNATURE_____
Original Signature Required

PROVIDER NAME (PLEASE PRINT)_____

DATE_____ PROVIDER PHONE NUMBER (___) _____

Patient must return this completed form to the County Health Department in order to receive her contraceptive method.

This order will expire one year from the date of the Initial/Annual Family Planning Visit noted above.